FORM 110-I
INJURY
Revised July, 2006

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, KY 40601

AGREEMENT AS TO COMPENSATION
AND
ORDER APPROVING SETTLEMENT

Workers' Compensation Claim No. _____

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.
Every section should be completed. If a section is not applicable, fill in the blank with N/A.

_____ Claimant

_____ Social Security Number Date of Birth

_____ Address

_____ City, State, Zip Code

_____ Employer

_____ Address

_____ City, State, Zip Code

_____ Insurer/Self-Insured/Self-Insurance Group

_____ Insurer's Address

_____ City, State, Zip Code

_____ Other participating parties

_____ Address

_____ City, State, Zip Code

INJURY

Date: _____ County in which injury occurred:_____
Brief description of occurrence resulting in injury:_____
_____
Nature of injury(ies) including body part(s) affected:_____

MEDICAL INFORMATION

Medical expenses paid: $_____ Date of last medical payment: _____
Medical expenses unpaid or contested:$_____
Surgery performed (*Circle one*): Yes No Nature of surgery:_____

Impairment ratings: (Attach entire medical report that provides ratings)

	Date Given	Physician
_____%	_____	_____
_____%	_____	_____
_____%	_____	_____

Restrictions on activities -- Attach most recent medical report setting forth physical restrictions.
Diagnosis or diagnoses:_____

If medical treatment is continuing, attach a copy of the executed Form 113 indicating a designated physician.

WORK INFORMATION

Type of work performed at time of injury: _____
Average weekly wage at time of injury: $_____ Date of return to work after injury: _____
Wages upon return to work: $_____ Type of work performed after injury:_____
Type of work performed at time of settlement: _____

BENEFIT AND SETTLEMENT INFORMATION

If consolidated Claims, indicate amount for each Claim separately:

Temporary total disability paid from _____ (MM/DD/YR) to _____ (MM/DD/YR) @ $_____ Amount * _____ # wks = $_____ Total

Monetary terms of settlement: _____ paid in lump sum ____, or weekly for _____ # of weeks

Settlement computation: _____
TTD * IMP. RATING *AMA FACTOR * RTW FACTOR * DISC. FACTOR OR # of WKS = TOTAL

Waiver(s) Please circle:			Amount for Lump Sum
Waiver or buyout of past medical benefits	Yes	No	_____
Waiver or buyout of future medical benefits	Yes	No	_____
Waiver of vocational rehabilitation	Yes	No	_____
Waiver of right to reopen	Yes	No	_____

Does settlement include Medicare Set Aside? Yes No If yes, amount of Medicare Set Aside: _____

Periodic Payments: _____ Amount * _____ Frequency * _____ Duration = _____ Total

Other: Attach explanation

If settlement terms provide for lump sum representing weekly benefits greater than $100, does claimant have an adequate source of income during disability? Yes No
Source of income:_____ Amount: $_____

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):
_____
_____
Other responsible parties against whom further proceedings are reserved: _____

If waiving medical benefits, please acknowledge by signing below:
I understand that my health insurance may not cover any medical expenses for my injury and I may be held responsible for payment of medical expenses for my injury. _____
Claimant (Signature)

If not represented by an Attorney, please acknowledge by signing below:
I understand that I have a right to obtain an Attorney of my choice to review this Agreement and by signing below I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an Attorney and this Agreement will be enforceable as if represented by Attorney. _____
Claimant (Signature)

_____
Attorney or representative for claimant (Signature)

_____
Attorney or representative for claimant (Name typed)

_____
Address

_____
City, State, Zip

_____
Claimant (Signature)

_____
Attorney or representative for employer (Signature)

_____
Address

_____
City, State, Zip

_____
Attorney for Special Fund (Div. of Workers' Comp Funds)

This the _____ day of _____, 20___.

DO NOT WRITE OR MARK BELOW THIS LINE

ORDER APPROVING SETTLEMENT AGREEMENT

IT IS ORDERED that the above Agreement as to Compensation be and the same is hereby **APPROVED.**

This the _____ day of _____, 20____.

_____
Administrative Law Judge